

# CBT-I Referral Form

ONLINE FILLABLE FORM AVAILABLE AT DALEDECKER.NET

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## PATIENT INFORMATION

First name	Last name
<input type="text"/>	<input type="text"/>
Date of birth	Phone number
<input type="text"/>	<input type="text"/>
Email address	
<input type="text"/>	
Insurance / Payor (or Self-pay)	
<input type="text"/>	

## REFERRING PROVIDER

Provider name	Specialty / Role	
<input type="text"/>	<input type="text"/>	
Practice / Clinic		
<input type="text"/>		
Contact phone	Fax number	Email for correspondence
<input type="text"/>	<input type="text"/>	<input type="text"/>

## SLEEP COMPLAINT & HISTORY

Duration of insomnia	Nights affected per week
<input type="text"/>	<input type="text"/>

Insomnia type — check all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> Difficulty falling asleep (sleep onset) | <input type="checkbox"/> Waking during the night (sleep maintenance) |
| <input type="checkbox"/> Early morning awakening                 | <input type="checkbox"/> Non-restorative / unrefreshing sleep        |

Relevant sleep history & prior treatments:

## RELEVANT COMORBIDITIES

- |  |   |
|--|---|
| <input type="checkbox"/> Depression / mood disorder        | <input type="checkbox"/> Anxiety disorder         |
| <input type="checkbox"/> PTSD                              | <input type="checkbox"/> Chronic pain condition   |
| <input type="checkbox"/> Sleep apnea (diagnosed/suspected) | <input type="checkbox"/> Restless leg syndrome    |
| <input type="checkbox"/> Substance use history             | <input type="checkbox"/> Cardiovascular condition |

Current sleep-related or psychiatric medications (name, dose, duration):

## REFERRAL URGENCY

ROUTINE — Within 4 weeks

SOON — Within 2 weeks

URGENT — Within 1 week

## OTHER COMMENTS

Any additional comments or context for the treating therapist:

## PATIENT CONSENT & RECORDS

- |   |   |
|---|---|
| <input type="checkbox"/> Patient has signed ROI authorizing this referral   | <input type="checkbox"/> Patient prefers in-person  |
| <input type="checkbox"/> Patient is aware they may be contacted to schedule | <input type="checkbox"/> Patient prefers telehealth |